EXHIBIT 3
DATE 3-13-09
SB 271

Montana Association for Marriage and Family Therapy

SB 271
Licensure for Marriage and Family Therapists

- Currently, the federal government recognizes five mental health disciplines as core mental health professionals. These are (1) psychiatrists, (2) psychologists, (3) mental health clinical nurse specialists, (4) clinical social workers and (5) marriage and family therapists.
- Marriage and Family Therapists are recognized by the Department of Defense to provide Mental Health care to our troops and their families.
- The Montana Licensed Clinical Professional Counselors Association, and the Licensed Clinical Professional Counselors National organization, on their own websites have this to say about Marriage and Family Therapists:

  "Licensure requirements for (Licensed Clinical Professional Counselors) mental health counselors are *equivalent (italics added)* to clinical social workers and marriage and family therapists - two other mental health professional disciplines requiring a minimum of a masters degree....."
  http://www.nicnca.org/what.php and http://www.aamft.org/about/

- Montana and West Virginia are the only two states in the country that do not currently license the profession of Marriage and Family Therapy. A licensure effort will be taking place in West Virginia this year. Senate Bill 271 will ensure that Montana is not the only state in the country without a Marriage and Family Therapy License.
- A Marriage and Family Therapy curriculum requires specialized course work and clinical experience. Currently, in the US there are 55 master's programs, 20 doctoral programs, and 13 postgraduate institutes that are either accredited or candidates for accreditation by the American Association for Marriage and Family Therapy (AAMFT, 2003).
- Professional licensure is required to protect and inform consumers. Senate Bill 271 will help communicate areas of expertise and professional training to potential clients.
- The Montana Association for Marriage and Family Therapy has worked with a variety of practitioners over the years to develop the SB 271.
- SB 271 will not preclude members of the clergy or others that currently provide marriage and/or family counseling from continuing to counsel. The purpose of the SB 271 is to recognize the specialized expertise and training of Marriage and Family Therapists.

Mental Health, United States, 2002

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Chapter 21

Mental Health Practitioners and Trainees

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Another mechanism that has grown rapidly is the use of the World Wide Web. Almost all counseling departments have a departmental Web page. These Web pages typically describe the program and its requirements and provide access to course syllabuses as well as information about the faculty. In some cases, much of the application process to the program can be completed online. The ACA and several of its divisions and NBCC have informative Web sites. One of the features of a Web page is the ability to link to other information sources with the click of a computer mouse. The amount of information that can be conveyed quickly and easily is enhanced enormously, and this trend will continue into the future.

The use of electronic communication in counseling is a relatively recent phenomenon that has profound practical and ethical implications. Counseling organizations are attempting to come to terms with this fact in various ways. For example, both the ACA and NBCC have developed a code of ethics for Webcounseling. In addition, a variety of commissions and committees are studying these issues. Also, courses are being taught electronically, and entire degrees can be completed online. This fact raises the issues of accreditation, accountability, and quality. The use of real-time video for counseling sessions raises issues of confidentiality because the Internet still poses serious confidentiality questions.

Even more current is the Nation's awareness of the potential for national catastrophe and the emotional distress that results after disasters, whether manmade or natural. The events of September 11 have reinforced the need for professional counselors. Counselors, as well as numerous other individuals from various health care disciplines, were called upon to respond to the psychological needs of those directly or indirectly linked to the terrorist attacks. Crisis counseling and grief counseling was, and continues to be, an integral part of the healing process. Whereas counseling programs typically have offered training in crisis intervention and post-traumatic stress counseling, the need for further developing these courses has resulted in curriculum change. Looking ahead to the future, it is hard to predict the psychological impact these events had on people or how many incidences of post-traumatic stress disorder, along with other mental difficulties, may result. What is certain is that counselors were, and continue to be, available to help people acquire the behaviors, beliefs, decision-making skills, as well as the abilities to cope with the aftermath of crises and mental illness.

Marriage and Family Therapy

Marriage and family therapists (MFTs) are mental health professionals trained in psychotherapy and family systems and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples, and family systems.

Marriage and family therapy grew out of the public's demand for professional assistance with marital difficulties and from the development of a family systems therapy orientation by psychotherapy professionals and others (Nichols, 1992). From their beginnings in the 1930s and 1940s, MFTs have developed into uniquely qualified health care professionals who are federally recognized as a core mental health discipline, along with psychiatry, psychology, social work, and psychiatric nursing (42 CFR Part 5 Appendix C).

Federal law defines an MFT as "an individual normally with a master's or doctoral degree in marital and family therapy, and at least two years of supervised clinical experience who is practicing as a marital and family therapist and is licensed or certified to do so by the State of practice; or, if licensure or certification is not required by the State of practice is eligible for clinical membership in the American Association for Marriage and Family Therapy" (42 CFR Part 5 Appendix C). The Department of Labor defines MFT services as: "diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Apply psychotherapeutic and family systems theories and techniques in the delivery of professional services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders" (21-1013 Marriage and Family Therapists). Research has found the services provided by MFTs to be effective (often more than standard treatments) for many severe disorders and to result in improved outcomes in both the health and functioning of clients (Doherty and Simmons, 1996; Pinsof and Wynne, 1995).

The profession of marriage and family therapy has burgeoned since the 1970s, with the number of therapists increasing from an estimated 1,800 in 1966 to 7,000 in 1979 to almost 50,000 currently.

Demographic and Training Characteristics

An estimated 47,111 MFTs were clinically active in the United States in 2001 (see table 1). Females represent two-thirds of practicing MFTs (see table

2), and the median age is 53 (Northey, 2002; Riemersma, 2002).

Consistently, African-Americans and those of Hispanic descent are underrepresented among MFTs, compared with their proportions in the U.S. population. As table 2 shows, the ratios of MFTs of Asian origin and Native Americans are more in line with their representation in the total population. As in the other mental health disciplines, Whites are significantly overrepresented, making up 93 percent of MFTs, compared with 75.1 percent of the U.S. population. Gender differences exist, however. Slightly more minorities are found among male than female MFTs (8.5 versus 6.2 percent). Increased representation of minorities among MFTs appears promising. Almost 22 percent of the students enrolled in 2002 in training programs accredited by the Commissions on Accreditation for Marriage and Family Therapy Education (COAMFTE) are from minority population groups.

Table 3 reveals that the distribution of marriage and family therapists varies considerably across the United States. These variations can be explained by the existence (or lack thereof) of State regulation of the practice of marriage and family therapy or the presence of accredited university/college training programs. MFTs have strong representation in rural areas, with 31.2 percent of rural counties having at least one MFT.

In 2001, an estimated 27,467 individuals were in training to be MFTs (see table 8). This includes an estimated 17,298 students in 166 master's and doctoral degree programs and 10,169 who have graduated but are not yet practicing independently.

The primary agency recognized by the U.S. Department of Education for the accreditation of clinical training programs in marriage and family therapy at the master's, doctoral, and postgraduate levels is COAMFTE of the American Association for Marriage and Family Therapy (AAMFT). COAMFTE accreditation is required for programs to establish eligibility to participate in Federal programs. COAMFTE also is recognized by the Council for Higher Education Accreditation (CHEA, formerly CORPA), a nonprofit organization of colleges and universities that coordinates and provides oversight of accrediting bodies. As of 2002, COAMFTE had accredited or in candidacy status 55 master's degree, 18 doctoral degree, and 14 postgraduate degree programs in 36 States.

Over three-quarters of MFTs in clinical practice hold a master's degree (78 percent) with another 22 percent having doctoral degrees (Northey, 2002; Riemersma, 2002). Forty-five percent of MFTs received their degree in marriage and family therapy. Upwards of 90 percent of MFTs are licensed as marriage and family therapists in their States (Northey, 2002; Riemersma, 2002).

Almost three-quarters (72 percent) of the estimated 47,111 clinically active MFTs in 2000 completed their training more than 10 years ago (see table 4), making them highly experienced as a group.

Thirty-seven of the 45 States that regulate MFTs require some continuing education. The average number of hours required is 35 per two-year renewal cycle. The mean number of continuing education hours obtained by MFTs is approximately 27 per year (Northey and Harrington, 2001; Riemersma, 2002).

Professional Activities

In 2000, most MFTs (53.8 percent) worked full time (see table 1), usually in one setting (37.8 percent) (see table 5). Further, most MFTs work in a private individual or group clinical practice (86.7 percent) at least part time (see table 6). However, the number of MFTs who work exclusively in private practice settings (50 percent) seems to be dropping. There is a concomitant shift in the numbers of MFTs working in public sector jobs, with 52.1 percent of the MFTs employed full time working in hospitals, academic settings, clinics, or social service settings (see table 6).

Increasingly, as shown in table 7, MFTs are involved in roles other than direct treatment, such as administration of human service and agency settings (56.0 percent), teaching (46.7 percent), and research (16.5 percent), as well as other activities, such as prevention program development, public welfare (especially child welfare through family preservation services), public policy development, client advocacy, consultation to businesses, and, more recently, managed care case management (Doherty and Simmons, 1996). On average, MFTs work 32 hours per week, seeing 18 clients (Northey, 2002).

MFTs treat the full spectrum of the American society. More than half the clients seen are female (57 percent); 24 percent are racial and ethnic minorities (Northey, 2002); and 64 percent of MFTs say they feel competent from their training to treat racial and ethnic minorities (Doherty and Simmons, 1996). About half the adult clients of MFTs have a college or postgraduate degree, whereas the other half have a high school degree and some college. Cli-

ents range from infants to seniors with a median age of about 38 (Doherty and Simmons, 1996).

MFTs treat a wide range of individual, couple, and family problems. Depression, marital and couple difficulties, anxiety, parent-adolescent conflict, and child behavior problems are the five most commonly cited presenting problems (Northey, 2002).

The presenting problems treated by MFTs tend to be severe. Nearly half (49 percent) of the problems are rated as severe or catastrophic; another 45 percent moderately severe; and six percent mild. The severity of client problems is further supported by the fact that 29.3 percent had been hospitalized in the past year, and 6.1 percent were hospitalized while under treatment by the MFT (Doherty and Simmons, 1996).

Despite their focus on family systems, MFTs do not treat only couples and family units. Indeed, nearly half the cases seen by MFTs are individuals (42.5 percent), 22.7 percent are couples, and 16.5 percent are families (Northey, 2002). A significant proportion of the clients seen are children (28.3 percent).

Clients report being highly satisfied with the services of MFTs. In a national survey of clients, 98.1 percent rated the services as good or excellent; 97.1 percent said they got the kind of help they wanted; and 91.2 percent said they were satisfied with the amount of help they received. Furthermore, 94.3 percent said they would recommend their therapist to a friend (Doherty and Simmons, 1996).

Clients also reported overwhelmingly positive changes in functioning: 83 percent reported that their therapy goals had been mostly or completely achieved. Nearly 9 out of 10 (88.8 percent) reported improvement in their emotional health; 63.4 percent reported improvement in their overall physical health; and 54.8 percent reported improvement in their functioning at work (Doherty and Simmons, 1996).

Treatment by MFTs is naturally brief and cost-effective. The average length of treatment is 11.5 sessions for couples therapy, 9 sessions for family therapy, and 13 sessions for individual therapy. The average fee is $80 per hour, which makes the average cost per case $780 (Doherty and Simmons, 1996).

As of the end of 2003, 46 States and the District of Columbia regulated the practice of marriage and family therapy. The latest to pass a licensure bill was the District of Columbia, in November 2003. California was the first State to regulate the profession in 1963, followed by Michigan in 1966 and New Jersey in 1968. The most impressive growth in State regulation began in the 1980s, with the vast majority of State regulatory laws having been adopted since 1980.

All MFT licensure laws regulate the profession at the independent level of practice. The most common title for regulation is Licensed Marriage and Family Therapist, although a few States use Licensed Clinical Marriage and Family Therapist. Arizona was the last State to regulate the profession through certification rather than licensure, but that law was amended in 2003. Many States also provide an interim certification or license for post-graduates who are obtaining their two years of clinical experience for a license.

States' definitions of the practice of marriage and family therapy vary in the specific language used, but are consistent with AAMFT's Model Licensure Law, which states the following:

> "Marriage and family therapy" means the diagnosis and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Marriage and family therapy involves the professional application of psychotherapeutic and family system theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.

While the overwhelming majority (90 percent) of the 47,111 MFTs nationwide hold a State marriage and family therapy license, 24.2 percent hold additional professional licenses. This fact reflects the multidisciplinary nature of marriage and family therapy. The additional licenses include psychologist (2.7 percent), social worker (6.6 percent), professional counselor (12.1 percent), and nurse (2.9 percent) (Northey, 2002). Two-thirds (67.6 percent) of MFTs hold only a marriage and family therapy license. There has been a 41 percent increase since 1995 of licensees outside California. Regardless of their training, most MFTs (73.0 percent) describe their primary professional identity as marriage and family therapist (Northey, 2002).

Psychosocial Rehabilitation

Psychosocial rehabilitation (PSR) is a rapidly growing approach to working with individuals with severe mental illness in the community. Specifically, PSR programs usually provide any combination of